

September 2026

Claims Must Be Submitted First Before Submitting Clinical Documentation Through the EDI Solutions Portal

Attachments should never be submitted before the claim is submitted. Documentation submitted before the claim cannot be matched to the claim, which will result in delays and denials.

The Attachment Control Number (**PWK**) field must be created during the initial submission of the claim. This requirement applies to claims submitted through the AHCCCS Online Provider Portal, billing software or a clearing house.

1. Determine whether supporting documents is required prior to the submission of the claim, for i.e.; NEMT, behavioral health, secondary claim.
2. Generate a unique Attachment Control Number (PWK) during the initial claim submission process.
3. If a PWK number was not created during the initial submission, the AHCCCS 12-digit claim number can be used to attach the document to the claim.
4. If the PWK number was created during the initial submission of the claim, enter the PWK number in the Attachment Control Number (PWK) field in the EDI Solutions portal.
5. Submitters must verify all identifiers match exactly between the claim and the attachment.

Examples:

Correct:

During the initial claim submission, the provider created the (PWK) number (A1234567808052026).

After the claim was submitted, the provider uploaded the supporting documentation through the EDI Solutions Portal. The provider entered the exact Attachment Control Number (PWK), (A1234567808052026), in the Payer Claim Control Number field.

Incorrect: An example of mismatch of this information may be (a12345678_080526), this does not meet the matching criteria and may prevent the documentation from being successfully associated and linked to the appropriate claim.

Training Resource [www.azahcccs.gov/Resources/ Downloads/ DFSMTraining/2025/EDIPortalWebUploadAttachmentProcess.pdf](http://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2025/EDIPortalWebUploadAttachmentProcess.pdf)

The [DFSM Claims Clues](#) is a monthly newsletter that provides information about changes to the program, system changes/updates, billing and FFS policies.

Report an Incident, Accident, and/or Death in the AHCCCS QM Portal FFS providers are required to report any Quality of Care (QOC) Concerns and Incidents, Accidents, and Deaths (IADs) as soon as they are aware, and no later than 24 hours after discovering the issue. Reports should be submitted through the QM portal.

Claims, Prior Authorization and Provider Enrollment inquires: The Division of Member and Provider Services (DMPS) manages the service calls for AHCCCS Fee-for-Service. DMPS can assist providers with prior authorizations, claim inquires and status and provider registration (APEP) questions and processes.

The hours of operation are Monday – Friday, 8:00am-5:00pm (602-417-7670).

AHCCCS Provider Enrollment Portal (APEP): Questions regarding provider-related enrollment, policy, or APEP user issues email APEPTrainingQuestions@azahcccs.gov. Your email will automatically create a service ticket to Provider Enrollment for assistance.

AHCCCS Warrants - For questions about Warrants, paper EOBs or Electronic Fund Transfers (EFT), contact the Division of Business & Finance (DBF) at (602) 417-5500.

835 Electronic Remittance Payment Sign Up (Remittance Advice Sign Up/835) Contact: ServiceDesk@azahcccs.gov or call (602) 417-4451

To upload documents to the new EDI Solutions portal [ServiceNow](#), users will need to have access. If you do not have an account, please follow the instructions outlined in the [EDI Portal Provider Signup and Login Guide](#).

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the [DFSM Provider Training Web Page](#).

For provider training questions please outreach the Provider Training Team via email at ServiceDesk@azahcccs.gov

COVID FAQ: [FAQ COVID Fact Sheet](#)

AHCCCS RFGA Funding Updates

AHCCCS is providing important updates regarding the following AHCCCS Request for Grant Applications (RFGAs):

- [YH27-0021: Medical Diagnostic Equipment and Technology, incl. EHR Upgrades & Data Sharing Initiative](#)
- [YH27-0022: Telehealth Digital Transformation, Adoption, and Care Coordination Grant](#)
- [YH27-0023: Rural Health Innovative Care Pilot Program](#)
- [YH27-0024: Technical Assistance for Operational and Fiscal Performance](#)
- [YH27-0025: Adopt Shared Services Consortia](#)
- [YH27-0026: Expansion of Mobile Digital Services, Training & Recruitment, and Prevention Programs Addressing Suicide, Trauma, and Substance Use](#)

1. Applicant Eligibility Clarifications

We recognize that the eligibility information in the published RFGAs and EUNA may not have fully conveyed eligibility for the following healthcare organizations, and we acknowledge any confusion this may have caused:

- Managed care organizations;
- Provider associations;
- Anchor institutions;
- Community based organizations serving rural populations include healthcare providers; and
- Colleges with rural health programs.

EUNA Grants is being updated to include the above categories as eligible applicant types, and amendments to the published RFGAs will be issued to reflect this change.

2. Q&A Update

Amendments for YH27-0021 and YH27-0022, which include responses to submitted questions, were posted to EUNA Grants on August 11, 2026. Moving forward, Q&As will be posted for each grant as an amendment approximately one week before the grant applications are due.

3. Grant Submission Extensions

Additionally, the application deadlines for YH27-0021 and YH27-0022 will be extended by one week, from August 14, 2026, to August 21, 2026. The revised deadlines will be reflected in the applicable RFGA amendments and EUNA Grants.

Please continue to check out EUNA Grants for updated information and RFGA amendments. Applicants should review all applicable amendments in conjunction with the original RFGA when preparing an application.

Questions regarding this update may be directed to RHTP@azahcccs.gov.

Skilled Nursing Facility Claims Denying with Remark Code H189.1

AHCCCS has identified an issue affecting Skilled Nursing Facility claims that has resulted in claims incorrectly denying with the denial remark code H189.1, **“Recipient Has Medicare; Medicare Must be Indicated, is Missing”**.

AHCCCS is actively working to implement a resolution and will reprocess all claims affected by this issue. **Providers do not need to resubmit affected claims.** AHCCCS will automatically reprocess impacted claims until the issue has been resolved.

Additional communication regarding claim reprocessing timelines and schedules will be provided as more information becomes available.

AHCCCS appreciates your patience and cooperation as we work to resolve this issue.

Catalyst Behavioral Health Training

The **Catalyst Behavioral Health Training** is a comprehensive 16-module series designed to help AHCCCS-registered behavioral health providers strengthen their knowledge, enhance compliance, and improve service delivery. The program offers practical guidance on AHCCCS requirements, covered services, documentation, quality management, billing, and fraud, waste, and abuse prevention.

Registration is now open for the first eight modules, which cover topics including:

- Arizona Behavioral Health System Overview & Medicaid 101
- Fraud, Waste, and Abuse (FWA)
- Human Rights in Healthcare
- AHCCCS Resources, Websites, FAQs, and the Medical Policy Manual
- Provider Participation Agreement Review
- Quality Management (QM)
- Covered Behavioral Health Services Guide (CBHSG)
- Utilization Management and Utilization Review (UM/UR)

All sessions are offered virtually and are designed to support providers at every stage, from those new to Arizona’s behavioral health system to established organizations seeking to strengthen performance and compliance.

New AHCCCS Eligibility Training Resource Guide

AHCCCS has posted a new training eligibility lookup guide to support providers in verifying AHCCCS eligibility for American Indian and Alaska Native (AIHP) members.

This guide serves as a quick reference to help providers understand eligibility considerations and identify available tools and resources that support timely eligibility verification and care coordination. It is especially useful for provider staff involved in admissions, eligibility verification, billing, and care coordination.

The guide is available here: [AHCCCS Medical and Behavioral Health Eligibility Lookup Guide for Providers for Care Coordination](#)

Dental Claim Submission Error Tooth Numbers

When using “JO” (ANSI/ADA/ISO Specification No. 3950) use two digits to indicate the tooth system. If a procedure is done to tooth 1 enter in 01. If a procedure is done to tooth 2, enter 02. Failure to list the tooth number in a two-digit format can result in return of the claim to the provider or denial.

H0004 and GT modifier

General Billing Guidance HQ (Group) Modifier

Billing for behavioral health in a group setting requires adherence to coding requirements, group size limits, and individual client documentation.

Use of the Group (HQ) Modifier: The **HQ modifier** must be appended to the applicable behavioral health service code when services are rendered in a group setting rather than on an individual, one-to-one basis. Behavioral health service delivered to multiple clients simultaneously is required to include the HQ modifier.

Failure to append, the HQ modifier when required will result in inaccurate billing and may directly affect reimbursement. This information is outlined in the [Behavioral Health B2 Matrix](#) and the [AHCCCS Covered Behavioral Health Services Guide](#) and follows standard billing criteria.

This billing guidance applies to service performed in a group setting, including both timed and per diem service codes.

Examples include but are not limited to the following:

- H0004 Behavioral health counseling and therapy, per 15 minutes,
- H2038 Behavioral Health skills training and development (timed),
- H2014 Skills training and development, per diem,
- H2018 Psychosocial Rehabilitation Services, per diem.

Behavioral Health Cloned Documentation: Documentation cloning is strictly prohibited.

Documentation & Time: Group progress notes must include complete and accurate documentation. As outlined in AMPM 940, documenting exact service duration, diagnosis, patient member's response to services, and the type and description of services provided during the group session.

Documentation must substantiate that the services billed were rendered as documented and provided in accordance with applicable billing and clinical requirements.

Examples include but is not limited to the duration of the service (time increments) which meets per diem requirements, signatures with credentials which demonstrates clinical qualifications and must contain documentation showing the differences and the needs of the patient for each visit or encounter.

AHCCCS Fee-for-Service Timely Filing: AHCCCS requires the initial claim be received within six months of the date of service. Initial claims submitted after the 6-month timely filing period are subject to denial.

Reference Sources:

AMPM 940 Medical Records and Communication of Clinical Information
AMPM 320-0 Behavioral Health Assessment, Service and Treatment Planning
AMPM 310-B Title XIX/XXI Behavioral Health Service Benefit

Intensive Outpatient Program Services (IOP) Event Type

Currently, Intensive Outpatient Program (IOP) prior authorization requests must be submitted using Event Type OP.

AHCCCS is currently working to add IOP as a selectable event type.

Until that update is available, providers should continue submitting IOP prior authorization requests using Event Type OP.

AHCCCS DFSM will send an email notification when the IOP option becomes available for use.

Medicare and Third-Party Liability Claims Correction

Providers are responsible for correcting errors that are a result of the direct claim submission. This applies to claims submitted on the AHCCCS Online Provider portal and direct EDI claim submissions.

Providers must submit a replacement/correction claim with any previously entered fields submitted with the correct information.

AHCCCS cannot edit/change or alter details entered by the provider.

This includes instances where Third Party Liability (TPL) and/or Medicare cost-sharing amounts were entered in the incorrect fields. If you are uncertain which fields should be used for Other (OTH) or Medicare amounts, leave these fields blank and submit a copy of the Explanation of Benefits (EOB) to ensure accurate processing.

Submitting a Correction/Replacement Claim

AHCCCS Claims Replacement: The initial claim must be received by AHCCCS within 6-months from the date of service to meet the timely filing period.

Step 1. Check the date(s) of service (DOS).

- Confirm the earliest DOS on the claim and verify the claim was received within 6 months of the DOS.

Step 2. Confirm the resubmission/adjustment is still **within 12 months of the DOS** (unless retro-eligibility applies).

- If the DOS is past the 12-month timely filing period and the provider submits a replacement claim, any payments issued **will be automatically recouped and the identified claim will be placed in Void status. No action will be taken on the replacement claim.**

Why NOT Sharing your User ID and Login Information is VERY Important

As an AHCCCS provider, you are responsible for all activities that occur under your AHCCCS Online Provider Portal account. Sharing account information is prohibited.

You are responsible for any activity conducted under your AHCCCS Online Provider Portal account that constitutes non-compliance with the Provider Participation Agreement, or that constitutes fraud, waste, or abuse.

You are responsible for all activities when your login ID and password are used.

Each time an individual logs onto the AHCCCS Online Provider Portal, the following message is displayed:

**** ATTENTION - SHARING ACCOUNTS IS PROHIBITED! **** Please remember that sharing account logins is prohibited and violates the AHCCCS User Acceptance Agreement.

You should NOT share your username and password with any other individuals. Each user must have their own web account. Access to the website can be terminated if the Terms of Use are violated. This means that even if two individuals work for the same facility, they cannot share usernames and passwords. Doing so would violate the AHCCCS User Acceptance Agreement.